



National  
**PACE**  
Association

**Written Testimony of Shawn Bloom**

**President & Chief Executive Officer  
National PACE Association**

**Submitted to the Connecticut Aging Committee:**

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Honorable David Zoni

**Tuesday, February 26, 2013**

## INTRODUCTION

Thank you members of the Aging Committee for holding today's vital hearing covering many aging related issues, including SB-882, which would add the Program of All-Inclusive Care for the Elderly (PACE) to Connecticut's Medicaid plan. My name is Shawn Bloom. I am the President and Chief Executive Officer of the National PACE Association (NPA). On behalf of the 92 PACE organizations that are members of the NPA and more than 27,000 individuals currently enrolled in PACE programs across the country, thank you for allowing me to submit written testimony to you today.

There are nearly 9 million individuals dually eligible for both Medicare and Medicaid – over 115,000 of whom reside in Connecticut. Dual-eligible Medicare and Medicaid beneficiaries often have multiple, complex health conditions. As a cohort, they are in poorer health and have lower incomes relative to other Medicare beneficiaries. They also happen to be one of the most expensive categories of beneficiaries served by federal health care programs.

In reviewing your state Long Term Care Plan 2013, 'Working Toward Real Choice for Long-Term Services and Supports in Connecticut', I applaud you for making clear your goal of 75% home and community based and 25% institutionalization for your nursing home eligible population. Further, your goal of working to find ways to support individuals to "Age in Place" is laudable, as well. AARP's 2011, *Aging in Place Study*, found that even when faced with the need for day to day care and ongoing medical treatments, most seniors (82%) and their families (71%) prefer for the senior to stay in their homes, rather than enter a skilled nursing facility.

The National PACE Association and its members understand the dual-eligible population very well. About 90 percent of PACE participants are dual-eligibles (eligible for Medicare and Medicaid). PACE exclusively serves the frailest subset of the duals, older adults requiring nursing home level of care. Such frail older dual-eligible beneficiaries served by PACE are precisely those who have the most complex treatment needs, have the highest health care expenses, and have illnesses and needs that place the greatest demand on family caregivers. Individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of daily living, such as eating, bathing, transferring, toileting and dressing. About half of our program enrollees have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older. Averaging 81 years of age, 30 percent are age 85 or older. Yet with all of these health needs, about only seven percent of PACE enrollees live in a nursing facility.

My written testimony will focus on three main areas. First, I want to briefly outline the history of the PACE Program and provide an overview of the PACE model of care, focusing on those elements that have made the program so successful in providing high- value, person-

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centered care to the oldest and frailest of the duals. Second, based on our experience, I will identify several ways that PACE will work within Connecticut's Long Term Care Plan and future goals. Finally, close with an offer to be a resource to committee and others who may have additional questions about PACE.

## **PACE HISTORY AND EXPANSION**

PACE was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco, California. On Lok originated in response to the local Chinese-American community's desire to provide comprehensive medical care and social services for its elders without placing them in nursing homes.

The PACE community-centered approach pioneered by On Lok proved so successful in enabling older adults to remain in their homes that the federal government extended the program to additional sites across the country through a demonstration program beginning in 1986. In the Balanced Budget Act of 1997, Congress authorized PACE as a permanent Medicare provider and Medicaid state option. In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country.

The number of PACE organizations has doubled in the last five years to 92 programs in 31 states. Today, PACE providers serve 27,000 enrollees in 31 states. Since its inception, on any given day, PACE enables over 90 percent of its participants to remain living in their homes, rather than permanently residing in a nursing home. There also has been more diversity among the types of interested sponsors during the past few years. For example, several hospice organizations now sponsor PACE programs and several others are developing PACE. Additionally, 13 rural PACE programs have been developed in the last four years operated by a range of different types of health care providers such as Area Agencies on Aging and community-health clinics.

States' interest in PACE also is growing, driven in large part by policymakers' desire to find better solutions to address dual-eligible beneficiaries' health care needs and, at the same time, to provide more predictability and control of their Medicaid payments to PACE. For example, Kansas has issued an RFP to providers for a statewide expansion of PACE as a potential strategy to improve care for the state's dually-eligible population. Almost all eligible frail elderly have access to a PACE program in New Jersey and Pennsylvania. This trend is continuing in other states, like Virginia and large areas of North Carolina.

We also understand that the need and desire for PACE likely will increase as the population ages and increasingly understands the benefits of integrated care. CMS currently has over 15 applications from programs seeking to create or expand PACE.

## **KEY FEATURES OF THE PACE PROGRAM**

The PACE program has three fundamental characteristics: (1) it is a community-based care provider, not a health plan; (2) it provides comprehensive, fully-integrated care; and (3) it is fully-accountable and responsible to its enrollees, their families and the government for the

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quality and cost of care it provides.

PACE is a community-based provider of care. Since its beginning as a demonstration program more than 25 years ago, PACE has provided innovative person-centered care for frail older adults that allows them to stay in their homes in the community, an option many families do not think is even possible. Without PACE, many of these frail adults would be in a nursing home. PACE is the recognized gold standard for older adult care and a model for how others looking to improve the system could succeed.

PACE provides comprehensive and fully integrated care. The PACE financing model bundles fixed payments from Medicare and Medicaid or private sources into one flat-rate payment to provide the entire range of health care services a person needs – including paying for hospital and nursing home care, when necessary. While a number of ideas are circulating about possible ways to coordinate care, PACE is a real program that has a long history of combining care into one seamless delivery package. Our programs are not large insurers primarily involved in approving and paying medical claims. Rather, they are the primary caregivers for the beneficiaries they serve. At the heart of the PACE delivery model is an interdisciplinary team (IDT) comprised of doctors, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers, and others who meet daily to discuss the needs of PACE participants. Through PACE's unified financing system, older adults receive individualized care that revolves around their unique needs and at a fixed payment amount.

PACE is accountable to its enrollees, their families and government, accepting full responsibility for the cost AND quality of care it provides. The result is better health outcomes, controlled costs and better value. PACE participants utilize, on average, about three days of hospital care annually. A 2009 interim report to Congress from the Department of Health and Human Services (DHHS) examined the quality and cost of providing PACE program services and found that PACE generates higher quality of care and better outcomes among PACE enrollees than the comparison group. PACE enrollees reported better health status, better preventive care, fewer unmet needs, less pain, less likelihood of depression and better management of health care. PACE participants also reported high satisfaction with their quality of life and the quality of care they received.

The bottom line is that PACE providers accept 100 percent responsibility for the cost and quality of care they deliver. The focus on prevention and wellness means avoiding unnecessary care and the escalating costs that go along with it. Through PACE's integration of all services, not just financing, costs are controlled and health care outcomes are high.

Perhaps the best way for the members of this Committee and others to understand what PACE does and what it means to the participants and families that it serves is to share the experience of one of our enrollees.

George is a 69 year-old who lives in the Southern Bay Area of Northern California. He

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has severe lung problems, heart failure and kidney disease. He lives alone in a single room occupancy hotel. He walks with a cane and has had several falls. He has short-term memory problems, needs help with bathing, meal preparation, housekeeping and shopping. By his own admission he —isn't good with taking his meds.

In the year prior to his enrollment in PACE, he had been admitted to the hospital four times. During the five-week period prior to enrolling in PACE, he had made three trips to the emergency room—usually complaining of shortness of breath or chest pain. He is on Medicare and Medicaid. He rarely makes it to doctors, primarily because he lacks access to reliable transportation. During his last emergency room visit, the physician who treated George discussed his concerns over George's progressive kidney disease and said George would —likely need dialysis treatments. Nevertheless, George did not keep his follow-up appointment with the kidney specialist. The hospital case manager made an entry into his record to —pursue nursing home placement with his next admission.

George was referred by a community social worker to the PACE program in the area. With the integrated payments of Medicare and Medicaid that are core to this program model, he now has access to a full team of on-site primary care physicians, clinic nurses, therapists, and social workers. The PACE program provides transportation to and from the center, as well as to outside specialists. His medications are directly managed by the clinic and home care team. He attends the center three times a week and on the other days a home care worker goes to his apartment to help with meals, medication and hygiene. He eats meals in the center and has meals delivered at home by the PACE program and his nutritional needs are directly overseen by a registered dietician.

Six months after enrollment, he has not been to the emergency room or to the hospital. His kidneys are functioning much better and there is no longer the concern of imminent dialysis. His blood pressure is also better controlled. He has had dental care and his ability to eat is also improved.

Each emergency room visit, with ambulance, costs an estimated \$2,500 and each hospital admission was close to \$10,000. Based on just his six month stay, PACE saved Medicare at least \$30,000. That does not even take into consideration the additional costs of dialysis that were likely avoided. A nursing home placement was avoided and the emergency room was no longer impacted by his frequent visits. Most importantly, George is more engaged with his own care, is more socially connected with other peers in the PACE program, and his quality of life has improved immeasurably.

As George's story shows, the existing PACE statutory and regulatory framework has allowed PACE organizations, together with CMS and states, to implement an effective model of care for dual-eligible individuals, over age 55, experiencing both major chronic diseases, and significant functional and/or cognitive impairments. We know this program works. It has a long track record of success and a nearly 17 year history as a permanent national program.

#### **COORDINATION WITH PACE AS CONNECTICUT IMPLEMENTS OTHER LONG TERM SERVICE**

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## AND SUPPORTS OPTIONS

As Connecticut works towards its goals of allowing people to 'age in place' while simultaneously striving towards rebalancing the state to 75% of the nursing home eligible to be served at home and in the community while up to 25% of them can be served in an institutionalized setting, the state must find programs and options that allow for safe transitions and effective and efficient care. According to the Long Term Care Plan, the state hopes to maximize its usage of Money Follows the Person (MFP) and apply for the Balance Incentive program (BIP) and Community First Choice (CFC) options. These are federal programs allow states to draw down funds from the federal government as well as gain enhanced Federal Medical Assistance Percentages (FMAP) for their Medicaid expenditures.

PACE can play a key role in helping Connecticut achieve these goals. One of the fundamental objectives of the MFP program is to transition individuals from institutional care back into the community. Since many institutionalized individuals have multiple physical impairments, this process is something that must be undertaken with a high level of care and experience. Since PACE specializes in this population and understands the myriad complexities that can arise from such transitions, they are well suited to partner in this work. PACE programs are also very effective at transitioning people from nursing homes to the community, for each individual transitioned from institutional care to the community, PACE programs will bear the full financial risk of costs associated with the transition and beyond. Additionally, it is each PACE provider's responsibility to ensure that the individual is safe in the community and to provide all assistance necessary for a safe transition. For each individual transitioned from an institutional setting into a PACE program, the state will receive enhanced FMAP funding from the federal government.

The Balancing Incentive Program (BIP) increases the FMAP to States that make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports (LTSS). The enhanced matching payments are tied to the percentage of a State's LTSS spending on home and community based care, with lower FMAP increases going to States that need to make fewer reforms. Through the BIP, states can receive an enhanced FMAP on their expenditures for PACE as part of an increase in the state funding for more community based long term services and supports. In order to estimate the portion of the Medicaid payment made to PACE that would be eligible for enhanced federal match payments, State and federal agencies need to calculate the portion that would be considered payment for qualified home and community based services – clearly the lion's share of the PACE payment.

Community First Choice is a newer state plan option to provide home- and community-based services in Medicaid Section, 1915(k); that first became available October 1, 2011. States that take up this option receive a 6 percentage point increase in federal matching payments (FMAP) for costs associated with the program. States may provide services to Medicaid-eligible individuals whose income does not exceed 150% of poverty. States that have set a higher Medicaid income eligibility level for those who require institutional care can use that higher income level. There must be a state determination that, but for the provision of home- and community-based services, the individual would need nursing facility care.

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The state will be providing to their program participants home and community attendant services in a community setting. Services for each participant must be based on an individual care plan developed through an assessment of the individual's functional need. There are currently no restrictions on state program expenditures.

States taking up this option must provide the following:

- Assistance with activities and instrumental activities of daily living (ADLs and IADLs) and health-related tasks, including hands-on assistance, cuing, and supervision.
- Acquisition, maintenance, and enhancement of skills to complete those tasks.
- Back-up systems, such as beepers, that will ensure continuity of care and support.
- Training on hiring and dismissing attendants, if desired by the individual.

States may also provide the following:

- Transition costs, such as the first month's rent; rent or utility deposits; and kitchen supplies, bedding, and other necessities for an individual to move from a nursing facility to the community.
- Coverage for additional items noted in an individual's care plan that will increase independence or substitute for personal assistance.

Standard plan exclusions include: home modifications, room and board, medical supplies, and assistive technology (except items that would meet the definition of back-up systems to ensure care continuity). However, when you contract with a PACE plan under this option, you are able to provide excluded items through PACE's expanded benefits, all within the fixed payment to the PACE provider.

## CONCLUSION

In closing, we once again appreciate the opportunity to submit this written testimony to the Committee. As mentioned, PACE has a proven track record of providing high quality care to the frailest segment of the dual-eligible population. While not all dual-eligible beneficiaries require the intensive services provided by PACE, for the individuals who do, PACE is a high quality, cost-effective alternative to permanent nursing home placement. PACE is community-based, comprehensive, and fully accountable for all risk. The PACE community would like to contribute to state and federal governments' efforts to improve health care for more dual-eligible individuals, and we look forward to working with you on these activities.

If you have any questions or would like any follow up information, please do not hesitate to contact Shawn Bloom at [shawnb@npaonline.org](mailto:shawnb@npaonline.org) or 703-535-1567.

Sincerely,

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